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ABSTRACT

A client's commitment to implementing treatment strategies is related to the client's commitment to achieving the treatment goals. However, treatment goals are often developed without full family participation and tend to be vaguely worded. These tendencies are addressed in this paper. A strategy was designed to increase therapists' skills in structuring the treatment planning process to increase client participation. That is, turning the process from a worker-generated treatment plan to one co-developed with the clients. The solution strategy consisted of developing and presenting a series of in-service workshops and follow-up interviews with the workshop participants. Analysis of results suggest that there were improvements in the participation of clients in the goal-setting process and in the development of objectively stated goals. Therapists reported that they were spending more time with clients; clients reported increased levels of understanding their problems and their causes. Although therapists were trained in the wording of treatment goals so that the goals were specific, observable, action oriented, and incorporated frequency and time elements, results show only modest improvements in this area. (RJM)

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Increasing Family Commitment to Treatment Goals Through In-service Training on Goal Setting and Communication Skills

by

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A Practicum Report Presented to the
Master's Programs in Life Span Care and Administration
in Partial Fulfillment of the Requirements
for the Degree of Master of Science

NOVA SOUTHEASTERN UNIVERSITY

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ABSTRACT

Increasing family commitment to treatment goals through in service training on goal setting and communication skills. Pope, Stan W., 1996: Practicum Report, Nova Southeastern University, Master's Programs in Life Span Care and Administration. Descriptors: Assessment/Treatment Planning/Goal Setting/Staff Training/Parent Cooperation/Staff Development/Client Motivation.

Client commitment to implementing treatment strategies is related to the client commitment to achieving the treatment goals. The problem identified at the practicum agency was that treatment goals were often developed without full family participation and tended to be vaguely worded which resulted in reduced client commitment to these goals.

The author designed and implemented a strategy to increase worker skills in the treatment planning process with clients. The author reviewed 10 sources that focused on goals, the goal setting process, and increasing clients' participation in the treatment planning process.

The solution strategy consisted of developing and presenting a series of in-service workshops, and follow-up interviews with the workshop participants. Results were evaluated by means of worker and client questionnaires, and auditing of the completed treatment plans and compared to the results compiled in the pre-implementation study. Analysis of results suggested that there were improvements in the participation of clients in the goal setting process and in the development of objectively stated goals.

Authorship Statement

I hereby testify that this paper and the work it reports are entirely my own. Where it has been necessary to draw from the work of others, published or unpublished, I have acknowledged such work in accordance with accepted scholarly and editorial practice. I give testimony freely, out of respect for the scholarship of other workers in the field and in the hope that my own work, presented here, will earn similar respect.

Oct 29/96 _____

Date Signature of Student

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CHAPTER I: INTRODUCTION AND BACKGROUND

The practicum setting is a Children's Mental Health Centre (Agency) located in a rural setting in central Canada. It consists of residential, day treatment, and family counselling programs. This practicum assignment will be primarily focused in the Day Treatment program. The Agency is 100% funded by the provincial government. The operating budget of the Agency for 1994-95 was 1.8 million dollars and the total number of residential and non-residential clients was 280. The Agency was incorporated in 1973. Its original mission was to provide youths with emotional and behavioral problems a camp experience with caring adults in order to re-instill a sense of trust and confidence in adults and a sense of personal success. It was comprised of two boys' residences (located in a wilderness setting) and a girls' residence and another boys' residence in a rural setting. It mainly offered services to families within the county.

By 1980, the Agency had begun to offer out-patient counselling (Clinical Response program) in order to help children and their families that did not require residential services. Also, the head office was moved to an adjacent county in order to provide services to families in that county.

In 1992 two new services were introduced, the Day Treatment program and the Family Response program. The Family Response program was instituted with a mandate to provide in-home support for families. The workers in this program help families develop and implement child management skills in the home.

Description of the Day Treatment Program

The Day Treatment program will be the target setting of the proposed practicum assignment. It is a program conjointly operated by the Agency and the local Board of Education (Board). It offers a special school to students that are experiencing severe difficulties in school. An important component of the Day Treatment program is the provision of counselling services to the families of the students enrolled in the program. The nature of the counselling is similar to that offered in the Family Response program but of a less intensive nature. The original one class program has expanded to five classes located in four schools spread over the two counties to which the Agency provides services. Each class consists of a teacher, youth worker, and up to eight students for a current total of 33 students and their families. The youth workers provide social skills training, counselling, and family work. The teachers are under the direct authority of their respective Boards and are responsible for providing the academic component of the program. The legal mandate of the program indicates that admission to the program is solely at the discretion of the Agency, however, a more co-operative decision making model has evolved over the life of the program, so that the Boards have been given an active voice in this process.

Profile Of The Youths Served

The students have been identified as having behavioural problems such as: aggressiveness, lack of compliance to authority, conduct problems, anxiety disorders, attention difficulties, and school refusal. As well, some of the students suffer from neurological disorders and learning exceptionalities. Many have histories of physical and sexual abuse, and unstable family relationships. Two of the classes serve

adolescents in a high school setting, one serves latency aged students in an integrated primary school setting, and two classes serve latency aged students in a segregated self-contained facility.

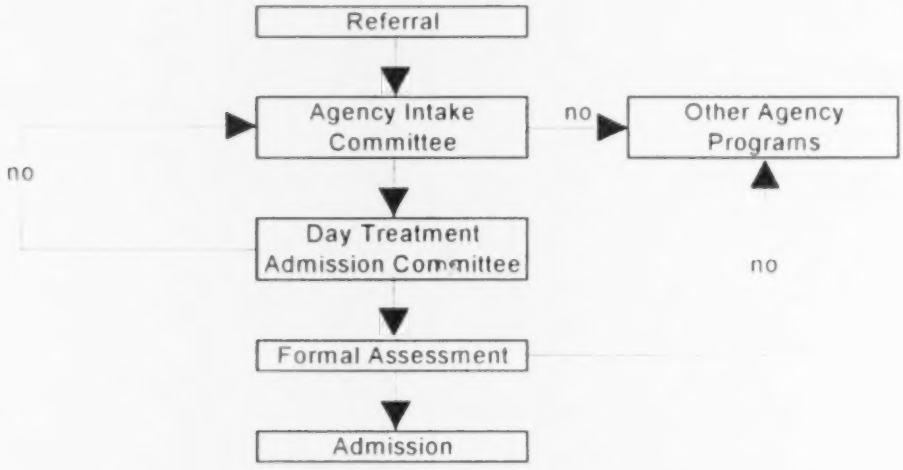
Referral and Admission Process

Figure 1 shows the decision making process for admission to the Day Treatment Program. Students and their families are self-referred to the program. Typically a family has been encouraged to contact the agency by the family physician, or the student's school. While the initial referral is, in theory, to the agency and not to a particular program, quite often the family would have specifically requested a program such as the Day Treatment program.

Once the referral information had been gathered by the intake worker, the case would have been initially reviewed by the Agency Intake Committee comprised of the Director, the Assistant Director, and the Program Supervisors for streaming to the appropriate program wait list. Subsequent to the referral being accepted into the Day Treatment wait list, the referral would then be presented to the Day Treatment Admission Intake Committee comprised of the Program Supervisor, the youth worker for the specific program, the psychologist of the Board, the program teacher, the Board's special education consultant and the principal that oversees the education component of the program. Information gathered by the Agency and by the Board would be shared and a decision would be made regarding the status of the referral (i.e. accept referral or send back to the Agency Intake Committee for re-assessment). If the decision was made to proceed with the referral, the agency would then conduct a formal assessment . This process would involve the gathering of all relevant records,

past assessments, behaviour checklists completed by the student's current teacher, and social history. As well, the consulting psychiatrist would meet with the student and the family. A conference would then be held where this information is reviewed by the Director, Assistant Director, the psychiatrist, and the program supervisor. this conference will result in a formal decision to provide Day Treatment or some other service to the family. The results of the Formal assessment would then be shared with the family by the program supervisor and a decision would be made with the family to proceed with the provision of the offered service or to re-conference at the request of the family.

Figure 1. Admission to the Agency Day treatment Program Process



If the family agreed to the Day Treatment program, a pre-placement visit would be arranged with the program worker and the teacher. During this visit, problems and

goals would be discussed in a general way, the parent permission forms signed, and a start date would be agreed on.

Goal Setting Process

The formal treatment goals and intervention strategies are developed in the Plan of Service document at the time clients start the program. It is reviewed on a twelve week basis. This document is comprised of the following sections:

Problem Synthesis: The worker synthesises psychiatric, psychological and social assessment findings into a comprehensive description of the current family and student situation.

Client Guided Information Section: This section outlines the process by which the above assessment/evaluation findings are shared with the family, the degree to which the family is in agreement or disagreement with the findings and the re-negotiation of the problem definition (if necessary).

Agreement For Service: The signed contract outlining the Problems For Work and the Goals.

Problems For Work: The specific problems which will be the focus of the interventions.

Goals: What will be the expected outcomes of the intervention. Worded in action terms, usually resulting in the increase or decrease of specific, measurable behaviours.

Client Intervention Strategies: Outlines the specific tasks of the clients to help remedy the problem.

Worker Intervention Strategies: Outlines the specific tasks the worker will perform to help the family develop and use more effective coping skills.

The Plan of Service document is prepared at the time of admission into the program by the youth worker assigned to the student and his or her family. As noted earlier, it is subsequently reviewed and either renewed or re-formulated every twelve weeks.

The Nova Student's Role In The Setting

The student was the Program Supervisor of the Day treatment program at the beginning of the practicum assignment. As such, I was responsible for the supervision of the youth workers in the program, I was a member of the Agency Intake Committee as well as the Day Treatment Admission Committee. Youth workers were responsible to me for the completion of the Plan of Service for the clients assigned to them, as well as for the implementation of these intervention plans. I had been employed at the agency for four years, two years in this position and two years previously as a social worker providing family counseling on the Clinical Response Team. During the course of the practicum assignment the Day Treatment program was re-structured with parts of it closing down and the rest coming under the supervision of the Assistant Director (the position now being called Treatment Director); while I became a member of the Clinical Response program providing out-patient counseling services.

CHAPTER II. THE PROBLEM

Problem Statement

In the Day Treatment program, workers consistently failed to involve clients in the treatment planning process to the level called for in the Plan of Service document. When clients were involved, there appeared to be a lack of clinical expertise in developing mutually agreed on problem definitions and goals. As well, goals that were developed tended to lack specificity and outcome indicators.

Description Of The Problem

In order to maximize client commitment to treatment goals, the Plan of Service document calls for active client participation in the problem definition and goal-setting process. As well, it calls for clear goals that are action oriented and time-limited, and measurable. It calls for the mutual agreement between the worker and client on the problem definition, the problems for work and the goals. Despite the explicit requirements for the Plans of Service, workers demonstrated difficulties in developing Plans of Service that met these criteria. Without agreement on clear, specific, and action oriented goals, the possibility existed for decreased client commitment to achieving goals, reduced treatment outcomes, and increased client drop-out from treatment.

Documentation Of The Problem

In order to establish the degree to which this problem occurred, I used three methods of data collection: a worker questionnaire, interviews with workers, and analysis of file recordings.

Questionnaire: A Worker Assessment of Treatment Goals questionnaire was distributed to eight workers which asked them about the clarity of client statement of problems and goals, and the degree to which there was the establishment of clear and specific goals. As well, it asked about the level of client agreement as shown by: attending sessions, implementing strategies, and keeping records (see Appendix A). The workers were asked to rate the degree to which each of the eleven question statements applied to individual cases. The rating scale was as follows: (0) never or not at all; (1) sometimes or somewhat or; (2) often or very true. The numerical ratings for each question were then compiled and average scores calculated.

Results: Thirty-eight questionnaires were completed by eight workers. Question #s 5,6,7 of the questionnaire focused on the results of the goal setting process between the workers and the clients. Question #5 asked whether clients are able to state clear goals. The average answer was sometimes or somewhat (average score: 1).

Question #6 which asked the degree to which goals are action based and include time elements scored an average of (1) which translated as sometimes or somewhat. Question #7 asked whether all parties agree on the goals. The average score for this was (1): sometimes or somewhat.

The results of this questionnaire indicated that setting clear, specific, action oriented and agreed upon goals with clients was only sometimes or somewhat achieved.

Question #8 referred to the degree to which clients implemented therapeutic strategies or tasks developed to attain the treatment goals. The results of this question again was sometimes or somewhat (average score: 1). If we accept the view that using therapeutic strategies is related to goal commitment and that goal commitment is partly related to explicitness of goals and agreement with goals (Hollenbeck and Klein, 1987, p.214); then it would appear from these results that the state of the goal setting process at that time was only somewhat successful at getting clients committed to the treatment goals.

Worker Interviews: Questions in these interviews related to how workers share assessment findings and diagnostic information with clients; is the goal-setting process structured or unstructured; how they involve clients in the process; how they handle disagreement during this process; and how they set goals with clients.

In my interviews with three workers I made the following observations:

- it was apparent that the workers had differing approaches to the goal setting and treatment planning process;
- none of the workers had received formal training in the process of sharing assessment data or goal setting with clients;
- one worker identified the problems for work in isolation from the clients and only later worked with the clients on getting agreement on the goals;
- one worker indicated that she found insufficient preparation time to present assessment findings to parents after the formal assessment;

- there was a tendency for the workers to adopt the role of the expert in that they attempted to convince the clients of the correct clinical view of the problem definitions and goals rather than co-developing these with the clients; and
- none of the workers clearly identified with clients the twelve week cycle of: identifying goals/ strategies -implementation of strategies -and evaluation.

Analysis of file records: I reviewed 10 case recordings examining the following documentation: completion of the Client Guided Information Section; analysis of the problems for work and the goals (were they specific, priorized, achievable, action oriented, and measurable); and completion of the Agreement for Service contract. In five of the cases there was no signed contract for service which identified problems and goals, none of the cases clearly specified when the treatment goals would be reviewed, and in four case recordings the Client Guided Information Section was not completed.

In reviewing the treatment goals, of the thirty-two treatment goals specified: 10 were specific, action oriented and observable (e.g. Jayson will do 1/2 hour of homework per night) while the rest were rather vague (e.g. Derek will increase / compliance to parent direction). None of the goals identified current level of the desired behaviour or of what increase would be striven for during the current treatment period. I also analyzed some of the goals which some of the workers had rated as (2) in their questionnaires. That is, they rated certain goals as being action based and included time elements. When I analyzed these goals, however, I was not able to put the goals in form: who does what under what conditions at what minimum performance level.

These results indicated: i) a lack of worker compliance to the proper completion of the Plans of Service; ii) goals were consistently worded using vague phrases open to interpretation; and iii) goals reflected worker values as opposed to being client driven.

Analysis of the Problem

There are certain factors that may contribute to the presence of this problem. There appears to be a lack of staff training in the areas of developing problem definitions and goals with clients. Procedural problems may also have a role in the problem in that workers proceed from the formal assessment conference to the problem definition phase with clients without sufficient time for the worker to prepare an adequate presentation of the assessment results to the clients. There is no clearly laid out procedure for discussing assessment findings or reaching agreement on the problems for work or goal-setting. Also, there is the historical use of the treatment planning process as a reflective tool for workers rather than as an interactive process with clients.

Literature Review

Hollenbeck and Klein (1987) discussed how individuals will carry out tasks related to attaining goals to the degree they are committed to the goals. In their expectancy model of antecedents and consequences of goal commitment they identified two major variables of goals commitment: attractiveness of goal attainment, and expectancy of goal attainment (see Figure 2). Each of these variables is in turn affected by two factors: situational and personal factors (Hollenbeck and Klein,1987, p.21). The treatment process can be viewed as a problem solving exercise whereby clients

undertake to solye an old problem by using new strategies. In this process problems are defined, goals and objectives are set, strategies for achieving the goals are identified and implemented and the results are evaluated as to whether or not the identified goals were achieved within the time specified (Compton and Galaway,1979,p.259). In order for them to apply the new strategies, clients must have sufficient commitment to the goals of therapy (Hollenbeck and Klein,1987,p.6). A person's commitment to goals is related to a number of factors including goal specificity, being achievable, and desirability of achieving the goals. The practicum problem is concerned with increasing client commitment to therapeutic goals through the development of worker skills in co-operative problem definition and goal setting with clients.

Figure 2 (From Hollenbeck and Klein,1987, p. 216)

Factors Related To Goal Commitment

Attractiveness of Goal Attainment	**Expectancy of Goal Attainment**
Situational Factors: publicness, volition, explicitness, reward structures	Situational Factors: social influence of others choice of goals, task complexity, supervisor supportiveness
Personal Factors: need for achievement, endurance, type A personality, organizational commitment	Personal Factors: perceived abilities, past successes, self- esteem, locus of control

The problem definition phase is the start of the treatment process where the therapist engages with the client system (Kagan, and Scholsberg 1989,p. 21). Clients often come to therapy with multiple and often ill-defined problems e.g. Arial has low self esteem. At other times they may come to therapy with problems that are in fact solutions e.g. Sarah needs a residential placement. The therapist's main aim at the start of the therapeutic process is to gather information that is clear, specific and stated in behavioral terms (Fisch, Weakland and Segal,1989, p.69). It is important to carefully identify the problem in order to have a focus for therapy (Epstein,1992, p.7). The problem should be agreed to by the client and the therapist (Epstein,1992,p.6). Problems should be clear and related to current life concerns (Epstein,1992,p.29). Who defines the problem is also a major issue in the problem definition phase. If the therapist is the one who defines the problem, the client may feel misunderstood, while if the client is solely responsible to define the problem, the therapist may be too constrained to be effective (Stewart, LaNar, and Amundson,1991,p.22). As well, different elements of the client system may disagree as to the problem definition. One of the key tasks of the therapist in this phase in the treatment process is to facilitate a problem definition that all parties can agree upon (Stewart, LaNar, and Amundson,1991,p.24).

In setting goals with families, it is important to establish a time frame for the therapeutic interventions. "Time limits maintain the anxiety needed to prompt both the family and the agency to deal with difficult issues" (Kagan and Scholsberg,1989, 113). It is also important for the therapist to understand the conflicting agendas of clients and therapists (see Figure 3).

Figure 3 (From Kagan and Schlosberg, 1989, p. 21)

Conflicting Agendas

Clients' Goals	Therapist's Goals
To reduce pain	To get into serious issues, thus often creating pain
To hide secrets that could threaten the family's balance	To help family members share secrets
To act out and avoid painful issues	To help families gain insight
To remain loyal to the family rules, beliefs and paterns of interaction, despite hardships for the individual	To help individuals grow and change for their personal good while maintainig psoitive connections to the family
To get someone to control them when they are out of control	To not control clients and, instead, have them learn to control themselves
To utilize all possible resources and energy to maintain a "no change" position	To promote change

In order to have the families be committed to the treatment goals, it is important for the therapist to accept reasonable family goals (Kagan and Scholsberg,1989,p.30). The therapist must help the client take a committed position by defining specific goals. Without specific goals clients may discount real improvements that they or their children have made (Fisch, Weakland and Segal, 1989 p.32). Minimal and achievable goals are also most likely to enhance commitment to goals, especially with those clients who demonstrate a high locus of external control and who have a low sense of personal efficacy (Hollenbeck and Klein,1987,p. 8).

CHAPTER III: GOALS AND OBJECTIVES

The goals and objectives of the project were derived from the problem statement:

> *"There appears to be a demonstrated lack of structure and clinical expertise in developing mutually agreed on problem definitions and goals with clients. As well, goals that are developed tend to lack specificity and indicators of intensity, frequency and duration."*

By the end of the practicum period, I proposed to achieve two major goals: increased worker skills in developing mutually agreed on problem definitions with clients; and that workers will develop with clients treatment goals that meet the criteria of being: specific, observable, achievable and measurable.

The achievement of these goals was accomplished through the meeting of specifically defined objectives. These objectives were derived from the worker task functions related to each goal (Austin, Brannon ,and Pecora, 1988, p.132).

Goal One

By the end of the tenth week, workers will demonstrate increased skills in developing mutually agreed on problem definitions with clients. This will be demonstrated through the workers presenting assessment/evaluation data to clients, the workers verifying the accuracy of the assessment data with clients, the workers soliciting client feedback regarding the assessment/evaluation results, and the workers formulating problem definitions with clients as a result of the client feedback of the assessment results. The workers will utilize the clinical skills necessary to reach agreement with clients on problem definitions, and they will help clients identify and priorize problems for work. Workers will construct with clients a list

of problems for work that reflect the client's priorities and which are also within the scope of the agency's mandate.

The indicators for achieving this goal will be higher scores in the Worker Assessment of Treatment Goals questionnaires (see Appendix A), higher completion rates of the Client Guided Participation section of the Plans of Service. As well, there will be a high level of client satisfaction with the process as evaluated in the Client Response questionnaires (see Appendix B).

Goal Two

Workers will develop with clients treatment goals that meet the criteria of being specific, observable, achievable and measurable. Workers will develop a list of treatment goals with clients that address the specific identified problems for work. Workers will demonstrate the ability to construct goals that meet the criteria of being achievable, specific, observable, and measurable.

The achievement of this goal will be indicated by higher ratings in the Worker Assessment of Treatment Goals and in the Client Response questionnaires. Also, analysis of the goals in the Plans of Service will show a higher frequency of goals that are specific, action oriented, observable, and measurable.

CHAPTER IV: SOLUTION STRATEGY

Literature Review of Solution Strategies

1. Stewart, K., La Nar V., and Amundson, J. (1991).

Success in therapy is often dependent on how the therapist is able to engage with the client at the start of the therapeutic process. They identified three crucial obstacles to overcome in the initial phase for successful therapy to occur: how the structure of therapy is defined, who provides the initiative for therapy, and who defines the problem for work.

These authors took the position that it is the function of the therapist to define the structure of therapy; it is the client that must take the initiative for therapy; and that the problem definition must be co-developed by the client system and the therapist. The focus of the article was on the last issue: the definition of the problem.

The authors made suggestions for clinical practice that would be applicable to the practicum goal of workers demonstrating increased skills in developing mutually agreed on problem definitions with clients.

2. Epstein, L. (1992).

Epstein discussed the importance of careful identification of the problem definition and target problems within the treatment planning process. He indicated that it is important to define the problem carefully in order to create a focus for therapy (Epstein, 1992,p.7). He described the three components of defining the problem. He described target problems as the problems for work that have been agreed to by the client and the therapist (Epstein, 1992,p. 6). He indicated that focusing on client goals

is the most practical way of conducting goal oriented therapy (Epstein, 1992,p.48). Epstein also identified the attributes of successful therapy outcomes (structured approaches that address specific problems, behaviors, or social skills; task centered problem solving and behavioral contracting; and achieving and maintaining a focus of therapy congruent with the client's definition of the problem.

Epstein proposed a classification of problems (such as: interpersonal problems, dissatisfaction with social relations, problems with formal organizations and so on) (Epstein, 1992,p.161). The target problems themselves are related to the current life concerns of the client. He indicated that there was a lack of evidence concerning whether or not addressing underlying problems was any more effective than focusing on target problems (Epstein, 1992,pp. 28,29).

Epstein proposed guidelines for facilitating client problem identification and identified therapist tasks in the process. The methodology that was proposed is relevant to the practicum goals and objectives related to increasing workers' clinical skills in helping clients define goals that meet the criteria set out.

3. Sanders, M.R., and Lawton, J.M. (1993).

Sanders and Lawton stated that a therapist's ability to develop a treatment plan that is accepted by clients is often determined by the therapist's ability to engage with the clients and to reduce client resistance (Sanders and Lawton, 1993, p. 6). In order to address this concern, they proposed the Guided Participation Model of Information Transfer (see Appendix C). This model is a step by step process that goes over the results of an assessment with them with a view to achieving agreement with clients on the definition of the problem, the causes of the problem as well as methods to correct

the problem. The model is consistent with the practicum assignment relating to the objective related to workers presenting assessment/evaluation data to clients that reflect on the child's interaction with significant systems (family, school, community, and peers).

4. Hollenbeck, J.R. and Klein, H.J. (1987).

In this work, Hollenbeck and Klein discussed the expectancy model of antecedents and consequences of goal commitment. Although more related to worker goal attainment within a work setting, the principals appear to be equally valid to the therapeutic process. The model they proposed states that goal commitment is seen to be a necessary precursor to goal attainment. The model identified variables that influence goal commitment. While it does not offer clinical guidelines for optimizing goal commitment, it could be a useful model for helping workers to assess client's ability to manage more difficult goals and hence, it may be useful in the construction of achievable goals.

5. Winton, P.J. and Bailey, D.B. (1988).

This article described the Family Focused Interview as collaborative mechanism for family assessment and goal setting. It was designed as a structured assessment and planning tool that helps ensure that important areas of family functioning are covered fully and that the generated family goals are the product of a collaborative effort. It was also described as a tool that helps to build trust and rapport with families. The model also identified worker clinical skill needed to develop an initial working relationship with clients. Both the structured interview format and the clinical skills section are

relevant to the practicum goals of helping workers in the practicum setting in developing skills in building consensus with clients in the areas of problem definition and goal setting.

In a further work on the subject, Bailey et al (1988) described an in-service program to train workers in fostering family goal setting through the use of the Family Focused Interview. The training consisted of a 3-day inservice training program. The components of the training that are most related to the current practicum problem included: preparing for the client interview, interviewing families, communicating with families, and specifying family goals. The results of this training indicated that there was an increase in the rate of family goals in the treatment plan of the children. While these results are not totally congruent with the objectives of this practicum, they demonstrate that an inservice training program teaching a structured interview format, communication skills, and the elements of sound therapeutic goals can be effective in improving worker skills in these areas.

6. Fleischman, M.J., Horne, A.M., and Arthur, J.L. (1983).

In their book, Troubled Families: a treatment program, Fleischman et al concluded that non-compliance in therapy often results from several factors such as: a lack of comprehension by clients about what they are expected to do, client goals not being fully addressed, and tasks that are too difficult or impractical. As a result, they designed a program that set out clear therapist agendas in the goal setting process that focuses on helping define clear problem statements and achievable goals. As well, they identified the clinical skills necessary for the worker to carry out the goal setting process successfully. This model appears to be relevant to the practicum

assignment. As well, the social learning assumptions are congruent with the agency philosophy.

Solution Strategy Selected

After reviewing the literature on the goal setting process and the different approaches used by the described programs I chose an approach that involved an inservice training program that addressed the specific objectives of the practicum (see Figure 4). Implementation of the inservice training occurred at the end of the school year when the youth care workers were no longer providing direct service in the school setting which allowed for their unencumbered participation.

Figure 4

Outline for Training

Topic	Skills Taught	Format	Length
Sharing assessment / evaluation with families	Using the Guided Participation Model for sharing information with families	lecture	2 hours
Communicating with families	Effective communication skills	lecture	2 hours
Goals in therapy	Awareness of the attributes of valid goals and factors related to goal commitment in clients	lecture, practice	2 hours
Specifying treatment goals	Using goal setting forms to operationalize treatment goals	lecture, practice	2 hours

In order to implement the solution strategy it was necessary to ensure that all the staff (5 in total) were available. This was accomplished by my having them book their vacation time subsequent to the training program. Another factor that was accounted for involved securing the permission from the executive director to proceed with such

an inservice training plan. As the solution strategy did not involve any changes to agency policy or philosophy, this permision was readily given. The implementation, by the workers, of the training content took place during the regular review and setting of new treatment goals with families during the ten week implementation phase of the practicum.

Documenting and Measuring Outcomes

The evaluation phase of the solution strategy attempted to assess the level to which the training provided the skills and knowledge outlined in the practicum objectives; and the degree to which the learning content of the training was used by the workers subsequent to the training (Austin, Brannon and Pecora, 1984,p.149). While there were a variety of evaluative instruments available, the Participant Action Plan Approach (PAPA) appeared to be the most cost effective approach for a small agency such as the practicum agency. This approach involved two phases:

a) At the beginning of the training session the participants were taught the principals of developing action plans. At the conclusion of the training session the workshop participants were asked to formulate action plans based on the information and skills learned in the training session. That is, how they planned to apply these new skills and knowledge on the job with clients.

b) Through interviews with workers I assessed the degree to which these action plans were implemented and maintained. This was limited as a result of my change of role within the agency during the time of the implementation.

As well, I conducted an analysis of case recordings examining the following

documentation.

- completion of the Client Guided Information Section; and
- analysis of the problems for work and the goals. Are they specific, priorized, achievable, action oriented, measurable.

Finally, during the implementation stage, I monitored how clients responded to the goal setting and strategies used by the workers by means of a post sessionClient Response questionnaire (see Appendix B). This approach was based on the approach used by Shilts, Filipino, and Nau (1994) to assess client response to the therapist and the content of the session immediately after a session.

CHAPTER V : STRATEGY EMPLOYED

Action Taken

The practicum problem has been stated as:

"There appears to be a demonstrated lack of structure and clinical expertise in developing mutually agreed on problem definitions and goals with clients. As well, goals that are developed tend to lack specificity and indicators of intensity, frequency and duration."

As noted earlier in the report, these problems are thought to effect the level of client commitment to treatment goals and would likely result in poor treatment outcomes (Chapter II, p. 9). The solution strategy that was developed to address these problems consisted of the development of an in-service training program that focused on developing worker skills in the goal setting phase of treatment. Specifically, this involved four workshops each two hours in length that addressed four topics:

-sharing assessment data with clients

-communication skills

-goals in therapy

-specifying treatment goals with clients.

This in-service training also included the development of worker action plans. In these plans the participants identified specific treatment practices learned in the workshops that they wished to incorporate in their clinical practice with clients. These action plans were then to be monitored on a regular basis by myself.

The implementation phase was, thus, divided into three separate segments. The first segment consisted of the development and preparation of the workshops for the in-service

training. The second segment was the in-service training involving the workshop presentations. The final segment was the on-going supervision of the participants to monitor the Action Plan implementation of the participants.

Workshop Development (Week 1&2)

The in-service workshops were developed during the first two weeks of the implementation period as opposed to the first week as called for in the Ten Week Calendar Plan (see Appendix E). This was due to the added length of the workshops (each one became two hours long) and that it took longer to put them together than anticipated.

The workshops themselves were designed in a similar fashion. For each one, the topic was introduced and the theoretical assumptions and clinical implications were presented in a lecture format (See Appendix F). This was followed by a series of role playing exercises using scenarios developed for the workshop. At the conclusion of the role-playing segment, there would a discussion period in which the participants discussed the techniques learned and their usefulness in the role play scenario. Finally, the participants would be asked to write out Action Plans (see Appendix G) based on the workshop materials. In these Action Plans the participants were to specify what behavioral changes they would make in their clinical practice over the following seven weeks of the implementation period.

Workshop Presentations (Week 3)

The original participant for the workshops were to consist of the five Day Treatment workers under my supervision. However, interest in the workshops from the Clinical

Response program (out-patient counseling) resulted in a total of nine workers who took part in the workshops. All four of the workshops were attended by the nine participants. While there was no formal evaluative mechanism for the quality of the workshops themselves, the participants displayed enthusiasm in the role plays and in the follow-up discussions. As well, comments after the workshop from the participants were positive and often reflected a desire for on-going opportunities for the workers to meet in order to share ideas and case related problems (at that time there was no formal mechanism for such peer group consultation).

At the conclusion of each workshop, the participants were asked to complete an Action Plan (see Appendix G) in which they were to identify specific strategies or techniques learned in the workshop that they would incorporate into their practice with clients. Some examples of strategies and techniques identified in these Action Plans included:

-"developing agendas for each family session in order to ensure a continued focus on goals and progress";

-"using the goal specificity guidelines in the development of goals with clients";

-"spend more time with clients going over assessment results and goal setting";

-"focus on client strengths and achievements and complete a self-check list after each client session";

-"become more goal focused instead of problem focused by using Solution Focused Strategies" (see Appendix F);

The workshop topics that the participants were most interested in were: the guidelines for developing clear and specific goals with clients; and the use of Solution Focused strategies in developing the worker/client relationship. While some of the workers noted

the importance of a thorough review of assessment results with clients, only one chose to implement the GPM model itself (see Appendix C). Most, however, did indicate that more time would be spent with clients in this area.

Monitoring of the Action Plans (Weeks 4-10)

A major change during the practicum implementation was the change in my role within the agency. Re-structuring of worker roles following the closing of one of the Day Treatment programs which I supervised resulted in my role being changed from a supervisor of the Day Treatment programs to that of a Clinical Response worker with no supervisory responsibilities. While this change did not affect the first two segments of the implementation phase (development of the workshops and the in-service training proper), it proved to have a negative impact on the third segment, namely, the monitoring of the Action Plans developed by the participants. The original intent was that I would be monitor Action Plan implementation through the regular supervisory meetings with the workers. However as a result of my role change, these monitoring sessions became irregular and the lack of a formal supervisory relationship with the workers resulted in decreased opportunities to guide the workers in their implementation of their Action Plans. The nature of the implementation of solution strategy thus changed from being a supervisory driven process to one of peer consultation and influence.

Sample size

In order to assess the impact of the staff training modules, I requested that each participant choose a sample five clients from their client group with whom the workers

would evaluate the goal setting process. While the potential was a sample size of forty-five clients among the nine workshop participants, several factors resulted in a reduced sample. One of the participants left the agency while three other participants experienced changes in their role descriptions which reduced their caseload sizes significantly. Of the other five participants in the practicum study, four chose not to participate in the data collection and the remaining participant submitted the data from one client. The final sample numbered eight clients which provide the qualitative data for evaluation of the practicum study.

Evaluation method

The evaluation method consisted of a worker completed Worker Assessment of Treatment Goals questionnaire (see Appendix A), and a Client Response Questionnaire (see Appendix B). I also requested that they submit the Plans of Service of their sample clients in order that I could evaluate the treatment goals and the extent of participation of the clients in the goal setting process. The surveys were designed to be brief and were designed to evaluate two major areas associated with the practicum objectives : to improve the objective nature of the treatment goals, and to increase client participation in the goal setting process.

Results of Worker Assessment of Treatment Goals Questionnaire

Nine questionnaires were completed by six workers. Questions 5,6,7 of the questionnaire focused on the results of the goal setting process between the workers and the clients. Question #5 asked whether clients were able to state clear goals. The

average score was 1.6 (often or very true) versus 1.1 (sometimes or somewhat) in the pretest questionnaire sample.

Question #6 which asked the degree to which goals are action based and include time elements. The average score was 1.5 (often or very true) as compared to .9 (sometimes or somewhat) in the pre-test questionnaire.

Question #7 asked whether all parties agree on the goals. The average score for this was 1.8 (often or very true) as compared to the average score of 1.2 (sometimes or somewhat) in the pre-test sample.

The results of this questionnaire indicated that setting clear, specific, action oriented and agreed upon goals with clients, as assessed by the workers, was often achieved in the post-test sample.

Results of Client Response Questionnaire

This was a post-test only questionnaire that asked clients to rate various aspects of their experience in the goal setting process. Question #1 asked if the assessment of the client's child had been presented in a clear and understandable manner. The average score was 2 (often or very true).

Question #2 asked if the client had a better understanding of the causes of the problem as a result of talking with the worker. The average answer was 1.5 (often or very true).

Question #3 asked if the client's ideas about the problem(s) and their causes had been taken into account by the worker. The average answer was 2 (often or very true).

Question #4 asked if the client and the worker were able to create clear goals that both were able to agree upon. The average answer was 2 (often or very true).

The final question asked the client to rate on a scale of 1(not useful) --10 (very useful) the service they were receiving thus far from the agency. The average score was 9.5 which indicated a high degree of satisfaction with the service being received.

These results suggest that clients viewed the goal setting process, subsequent to the in-service training, as a positive one that sought their input into the problems and that resulted in clear goals for themselves in the treatment process.

Analysis of file records

As in the pre-implementation phase, I once again reviewed the case recordings of the nine sample cases examining the following documentation: completion of the Client Guided Information Section, and analysis of the goals for their objective characteristics (were they specific, action oriented, and did they indicate frequency).

In eight of the nine cases, in this post-implementation sample group, the Client Guided Information Section of the Plan of Service document was completed; whereas in four out of the ten case recordings analyzed in the pre-implementation phase the Client Guided Information Section was not completed. The post-implementation sample showed an 89% completion rate as compared to the 60% completion rate in the pre-implementation sample.

In reviewing the treatment goals, I rated the goals in the above sample group according to the degree the goals met the criteria for being treatment goals that consisted of objective characteristics. That is, were they specific, action oriented,

observable, and was there a frequency or rate of performance for the desired behaviour. Of the twenty treatment goals in the post-implementation sample group: ten, or 50%, were specific, action oriented and observable. This compared favorably with the results of the pre-implementation study in which only 31% (10/32) met the criteria for being objectively stated goals. Another characteristic of the goals that was analyzed in the pre and post-implementation phases was the degree to which the goals included frequency measures. In the pre-implementation study none of the thirty-two goals studied included a frequency indicator for goal achievement. In the post-implementation study, six of the twenty goals included such measures.

I also compared some of the sample goals to the ratings the workers gave those goals regarding objective characteristics. In five of the nine case samples studied in the post-implementation phase, the workers had evaluated their goals as meeting the criteria for objectively written goals. In comparing their evaluation with my review of these goals, I judged that in four of the five cases, the worker's evaluation was consistent with my evaluation of the goals. In another three of the nine cases the workers indicated that their goals did not meet the criteria for objectively written goals (which was also consistent with my rating). Hence, in eight of the nine cases studied, worker assessment of goals matched the rating I gave to the goals in regards to their objective characteristics.

Discussion

The first goal of the practicum project was that workers were to demonstrate increased skills in co-developing mutually agreed upon problem definitions and goals

with clients. This was evaluated in the review of the Client Guided Participation (CGP) section of the Plan of Service, and as evaluated in the Worker and Client Questionnaires. The results described in the previous section suggest that this goal was achieved. The completion rate of the CGP section in the post-implementation phase was 89% (an improvement over the 60% completion rate in the pre-implementation sample). The results of the Client Response Questionnaire indicated that clients reported that the assessment of their child's problems had been often presented in a clear manner, that they had a clearer understanding of the causes of the problem, and that their opinions and views had been taken into account by the worker during the goal setting process. The majority of the clients also reported that the process had been useful to them. The Worker Assessment of Treatment Goals questionnaires results indicated that there was more agreement on the goals by all parties in the post-implementation group as compared to the pre-implementation study. These results, I believe are indicative of increased worker skills in the treatment planning process with clients.

The second goal of the practicum project was to increase the objective nature of the treatment goals. This was evaluated by the ratings in the Worker's and Client's questionnaires and by my analysis of the goals in the sample treatment plans completed by the workers in the post-implementation phase. As outlined in the previous section, 50% of the goals I evaluated met the established criteria for being objectively written goals. This compared favorably to pre-implementation rate of 31%. Similarly, goals that included frequency measure occurred in 30% of the goals in the post-implementation phase. This, again, was an improvement over the 0% rate in the

pre-implementation study. These indicators suggest a modest improvement in the workers skills in developing that objective in nature and that include frequency rates. Also of note, some of the workers appeared to be better able to assess whether or not treatment goals met the established criteria for being objectively stated even if the goals themselves did not meet the criteria. That is to say, some workers were better able to identify their own goals as being vague and unspecific. This may indicate an increased awareness, in these workers, of the of the criteria for developing objectively written goals.

In my discussions with the workers in the post-implementation phase, many noted that they were spending more time with clients in the treatment planning and goal setting stage. They indicated through the questionnaires and in these discussions that this appeared to be helping them to develop effective working relationships with their clients. The development of more objectively worded goals, on the other hand, seemed to be more difficult for the workers. Although they appeared to be able to evaluate goals in terms of their objective characteristics (in the workshop exercises and in the Worker questionnaires), they continued to have difficulty in actual construction of objectively stated goals. It may be possible that learning this new skill requires more on-going feed-back from peers and supervisors. Workers and supervisors may also be uncomfortable with some of the concepts of objectively stated goals. One supervisor commented that setting specific frequency rates for desirable behaviors would turn the workers into "bean counters". One of the workers felt that setting objective standards for treatment goals ran counter to her view of the treatment process as more art than science. Interestingly, this was one of the workers that that was successful in

developing goals that were objective in nature. Yet other workers maintained that specific objectives in their treatment plans could be found in Intervention Strategies section of the Plan of Service. A review of these sections, however, failed, in my opinion, to substantiate these claims. It would appear that more training and supervision is required to help workers increase their skills in this area.

CHAPTER VI: CONCLUSIONS AND RECOMMENDATIONS

Brief Review of Outcomes

The purpose of the practicum project was to increase the level of client commitment to treatment goals by increasing worker skills in the goal setting process. This was broken down into two major goals. The first goal was to increase the workers' skills in structuring the treatment planning process in a way that increased client participation in the process. That is, turning the process from a worker generated treatment plan to a co-developed treatment plan with clients. In order to accomplish this, in-service workshops on sharing assessment data with clients and Solution Focussed treatment planning strategies were held with front-line workers.

Results suggested that this goal was, to a large measure, achieved. Workers reported that they were spending more time with clients in this process, and clients reported increased levels of understanding of the problems and their causes. They also reported that their input had been incorporated into the goal setting process.

The second goal involved increasing the objective characteristics of the treatment goals themselves. This involved training the workers in the wording of treatment goals so that they were specific, observable, action oriented and incorporated frequency and time elements. This training was also accomplished by workshops held with the workers that presented these concepts and incorporated various exercises to help the workers develop competency in the their applications.

Results suggested only modest improvement in this area. This was indicated by worker evaluations of treatment goals and in the analysis of sample goals.

The workshops themselves were well received as shown by the 100% attendance rate over the four days the workshops were held. Even those workers attending on a voluntary basis attended all of the sessions. Many workers expressed the desire for more of these type of workshops which stressed experiential learning (e.g. role-plays) as well as the didactic material.

A change in my role at the agency during the project resulted in reduced opportunities for monitoring the workers' implementation of the new goal setting strategies and goal statement criteria. This may have contributed to the less than desired outcome in regards to the second goal of improving the objective characteristics of treatment goals. This could have been addressed by the scheduling of weekly hour meetings with the workers where their ideas and feed-back could have been shared with myself and among themselves.

Implications of Results

The clinical importance of careful and methodical treatment planning with clients was explored within this report. The more clients are included in the treatment planning process the higher the likelihood of their commitment to the treatment process itself. Clearly defined goals that are achievable and observable also increases their commitment to achieving these goals. There is, also, an increasing need for valid outcome measures in the field of child and youth care. Traditional approaches to the treatment of youth with emotional and behavioural problems and their families are coming under increased scrutiny in regards to their efficacy by funding sources (Gabor and Grinnell, 1994,p. 4). This is in part due to the reduced resources allotted for such programs. Also, the increasing diversity of treatment approaches has resulted in increased

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Appendix A

Worker Assessment of Treatment Goals

Date _____
Name of parent _____
Name of child _____
Therapist _____

For each question please insert the number you think comes closest.

(0)-Never or not true
(1)-Sometimes or somewhat
(2)-Often or very true

1 States that [s]he wants help with a problem _____
2 Volunteers information about problems of family interaction _____
3 Answers questions about the problem clearly _____
4 Able to accept the impact of their behaviour on the problem situation in positive and /or negative ways _____
5 Clients able to state clear goals _____
6 Goals are action based and include time elements: how often, when, and how long _____
7 All parties agree on the goals
Consistently applies strategies taught

Appendix B

Client Response Questionnaire

Date _____

Name of parent _____

Name of child _____

Worker _____

For each question please insert the number you think comes closest.

(0)-Never or not true
(1)-Sometimes or somewhat
(2)-Often or very true

1 The assessment of your child's problem(s) was presented in a clear and understandable manner _____

2 As a result of talking with your worker, you had a better understanding of the causes of the problem(s) _____

3 Your ideas about the problem(s) and their causes were taken into account by the worker _____

4 You and the worker were able to create clear goals that you all agreed on _____

5 On a scale of 1-10 how useful would you rate this meeting?

Not useful 1 2 3 4 5 6 7 8 9 10 Very useful _____

Appendix C

Steps in the Guided Participation Model Approach of Information Transfer

1. Prepare for the session
   - review all relevant assessment data
   - decide on what information to convey
   - prepare worker's viewpoint of the problem and likely causes and treatment options, proposed goals and duration of treatment
   - prepare audiovisual aids where appropriate(graphs, charts, diagrams
   - be cautious about labels

2. Establish agenda with family
   - what have we found so far
   - what are the likely causes of the problem
   - options for dealing with the problem
   - aim is to reach agreement about the problem, the causes and therapy

3. Summarize the presenting problem and check that it is still relevant

4. Present descriptive information relating to the problem
   - types of information gathered [checklists, teacher reports, observation
   - present data from one assessment procedure
   - check parent's reaction and understanding
   - present results from next assessment procedure [continue until all assessment tools have been completed]

5. Summarize the problem
   - check for accuracy with the parents

6. Review causes of the problem
   - provide handout discussing common causes of behavior problems in children
   - develop a personalized list of factors that contribute to the problem

7. Present options for future treatment
   - cost/benefits of options
   - recommendations

8. Plan a schedule for future contacts [From Sanders and Lawton, 1993, pp.15-22]

Possible Causes of Children's Behaviour Problems

I. Genetic/biological factors

- Your child's temperament
- Your child's health (eating and sleeping patterns as well)

II. Daily interactions (learning and experience)

- Accidental rewards or punishments
- Escalation traps (from parent's and child's point of view)
- Learning through watching (parents, siblings, peers)
- Ignoring desirable behaviour
- Methods of instruction giving and rule making (too many, too few, too hard, too vague, rapid fire, poorly timed, body language)
- Using emotional messages (angry messages, guilt inducing messages, character assassinations)
- Negative communication (see handout)
- Ineffective use of punishment or discipline
- Parental disagreement on rules, discipline

III. Things that affect parents

- Stress and other personal problems
- Marital conflict
- Social support
- Financial Stress

IV. Any other factors

Appendix C, continued

Family Handout on Negative Communication

Check if your family does this	More positive way to do it
Call each other names	Express anger without hurtful words
Put each other down	I am angry that you _____
Interrupt each other	Take turns, keep it short
Criticize all the time	Point out good and bad
Get defensive when attacked	Listen carefully, check it out, then calmly disagree
Give a lecture	Tell it straight and short
Look away	Make good eye contact
Slouch or slide to the floor	Sit up and look attentive
Talk in sarcastic tones	Talk in normal tone
Get off topic	Finish one topic and go on
Think the worst	Keep an open mind
Dredge up the past	Stick to the present
Command, order	Ask nicely
Give the silent treatment	Say it if you feel it
Throw a tantrum, "lose it"	Count to 10; take a walk; leave the room
Make light of something serious	Take it seriously, even if minor to you
Deny you did it	Admit you did it , but say you didn't like the wayyou were accused

Appendix D

Ten Week Calendar Plan

Week 1: Development of the in-service training curriculum. This will include lecture development, audiovisual materials and training exercises.

Weeks 2-3: In-service training units. I will be responsible for the presentation of the training package.

Weeks 4-10: Youth workers to implement skills and procedures learned in the training program with families. My role will be to monitor this implementation through regular supervision with the youth workers. I will also be monitoring the impact on families by way of post session questionnaires given to these families.

Appendix E

In-service Staff Training: Session I

1. Agenda

2. Review Plan of Service: its elements

3. Review results from practicum proposal: Documentation of the problem as identified through interviews with workers and analysis of file records.

4. Training Objectives

Objective #1: Workers will be exposed to methods of presenting assessment/evaluation data to clients in a way that promotes a shared understanding and agreement on the problem definition.

Objective #2: Workers will develop an understanding of Solution Focussed Therapy techniques as a way of reaching agreement with clients on problem definitions and goals.

Objective #3: Workers will demonstrate the ability to construct goals that meet the criteria of being: achievable, specific, observable, and measurable.

Objective #4: Workers will develop a procedure to construct with clients a list of problems for work that reflect the client's priorities and which are also within the scope of the agency's mandate.

5. Outline of the In-service Training Schedule

Session I: Guided Participation Model of Information Transfer [GPM]

Session II: Solution Focused Therapy

Session III: Goals in therapy: the role of goals in the treatment process, goal commitment, attributes of effective treatment goals

Session IV: Specifying treatment goals: a model for the goal setting process with families

6. Development of Worker Action Plans

7. Presentation of the GPM

-background theory, hand out of article, agenda, causes of behaviour problems
-role play a GPM session using a current problem synthesis
-debriefing

7. Session Feedback

-hand out and collect Action Plan Idea Forms

Appendix E (continued)

In-service Staff Training: Session II

Practice Objective: Workers will develop an understanding of Solution Focused Therapy techniques as a way of reaching agreement with clients on problem definitions and goals.

1. Review Agenda

General assessment of child and family functioning including history of the problem, differing perspectives, medical, psychiatric assessments, past efforts at treatment was conducted in the Pre-service assessment phase ending with the formal assessment. The job of the worker at this point is to develop a working alliance with the family in order to resolve or ameliorate the major complaint that has brought the family to the agency. That is, what will be the problem(s) for work and the goals for the next 12 weeks of therapy that the family will be able to achieve that the worker and family are able agree on. Solution Focussed Therapy presents several concepts that may be of use in this process. The goal of today's session will be to develop an understanding of these concepts and their possible application to this process.

2. Basic Assumptions of Solution Focused Therapy (O'Hanlon, 1992)

- It is unnecessary to understand the cause of a symptom
- Insight and awareness are not necessary pre-conditions to change
- Preconceptions about clients hamper the therapist
- People can change
- Symptoms are not necessarily expressions of underlying pathology or past problems.

3. Assessment of the problem for work

- Client motivation. Is the person a visitor, a complainant, or a customer. It is important to assess who is most concerned about the problem-this may not be the identified patient.
- Obtaining a problem description. This is the workers principal activity: gather concrete information about the on-going interactions that characterize a problem. Ask for specific incidents and how this interferes with their normal lives. Identify the most important problem. Validate and acknowledge each person's feelings and points of view without closing down the opportunities for change. Reflect back these feelings and point of view in the past tense. Avoid confirming the clients certainty of their position e.g. " it looked to you...", "you had the impression that...". Create little openings in generalizations " most of the time...", "usually" and so on.
- Get a description of the attempted solutions. " How have you been attempting to handle or resolve this problem". Focus on observable behavior as opposed to

thoughts and feelings. "I can see that this problem is getting the best of you or you wouldn't be here to see me. But everyone tries as hard as they can to deal with problems and I wonder what you have been trying even though it has not worked as well as you would have liked". How do others react to what the client has been doing. Search for exceptions to the problem, don't try to convince them of exceptions let them convince you.

- Eliciting a goal statement: " At a minimum what would you hope to happen as a result of coming here". Seek a behavioral description of the interaction that could signify that the problem has been resolved. "Can you describe a situation that were it to occur you would know that a positive change had been achieved". Considerations: occurrence of a positive event, not the absence of a negative, small but strategic changes, principal of the unresolved remnant: The worker should never suggest the possibility of totally removing the problem, but only its improvement. This rejects the all or nothing approach and sets the stage for the client to achieve more than the workers apparent expectations.

4. Principals of Empowerment

5. Acknowledgement and possibility

7. Confrontative/collaborative approaches

8. Listen to Audio Tape of a counseling session that utilizes some of these concepts.

9. Action Plan Ideas

10. For tomorrow, develop a summary of some problem situation that you are trying to manage more effectively. Be as concrete and as specific as possible in this summary.

Appendix E (continued)

In-service Staff Training: Session III

Objective #3: Workers will demonstrate the ability to construct goals that meet the criteria of being: achievable, specific, observable, and measurable.

1. Review Agenda

2. Theoretical principals related to goal setting

Hollenbeck and Klein (1987) discussed how individuals will carry out tasks related to attaining goals to the degree they are committed to the goals. In their expectancy model of antecedents and consequences of goal commitment they identify two major variables of goals commitment: attractiveness of goal attainment, and expectancy of goal attainment (see Figure 1). Each of these variables is in turn affected by two factors: situational and personal factors. The treatment process can be viewed as a problem solving exercise whereby clients undertake to solve an old problem by using new strategies. In this process problems are defined, goals and objectives are set, strategies for achieving the goals are identified and implemented and the results are evaluated as to whether or not the identified goals were achieved within the time specified. In order for them to apply the new strategies, clients must have sufficient commitment to the goals of therapy. A person's commitment to goals is related to a number of factors including goal specificity, achievability, and desirability of achieving the goals

Figure 1 (From Hollenbeck and Klein,1987, p. 216).

Factors Related To Goal Commitment

Attractiveness of Goal Attainment	**Expectancy of Goal Attainment**
Situational Factors: publicness, volition, explicitness, reward structures	Situational Factors: social influence of others choice of goals, task complexity, supervisor supportiveness
Personal Factors: need for achievement, endurance, type A personality, organizational commitment	Personal Factors: perceived abilities, past successes, self- esteem, locus of control

3. Problem Definition Phase

The problem definition phase is the start of the treatment process where the therapist engages with the client system. Clients often come to therapy with multiple and often ill-defined problems . At other times they may come to therapy with problems

that are in fact solutions (e.g. Sarah needs a residential placement). The therapist's main aim at the start of the therapeutic process is to gather information that is clear, specific and stated in behavioral terms. It is important to carefully identify the problem in order to have a focus for therapy. The problem should be agreed to by the client and the therapist. Problems should be clear and related to current life concerns.

Who defines the problem is also a major issue in the problem definition phase. If the therapist is the one who defines the problem, the client may feel misunderstood, while if the client is solely responsible to define the problem, the therapist may be too constrained to be effective. As well, different elements of the client system may disagree as to the problem definition. One of the key tasks of the therapist in this phase in the treatment process is to facilitate a problem definition that all parties can agree upon.

4. Goal setting

In setting goals with families, it is important to establish a time frame for the therapeutic interventions. "Time limits maintain the anxiety needed to prompt both the family and the agency to deal with difficult issues" (Kagan and Scholsberg,1989, 113). It is also important for the therapist to understand the conflicting agendas of clients and therapists (see Figure 2).

Figure 2
Conflicting Agendas

Clients' Goals	**Therapist's Goals**
1. To reduce pain	1. To get into serious issues, thus often creating pain
2. To hide secrets that could threaten the family's balance	2. To help family members share secrets
3. To act out and avoid painful issues	3. To help families gain insight
4. To remain loyal to the family their rules, beliefs, and patterns of interaction, despite hardships for the individual	4. To help individuals grow and change for personal good while maintaining positive connections to the family
5. To get someone to control them	5. To not control Clients and instead have them learn to control themselves
6. To utilize all possible resources to maintain a " no change " position	6. To promote change

In order to have the families be committed to the treatment goals, it is important for the therapist to accept reasonable family goals. The therapist must help in the definition of specific goals to help the client take a committed position. Without specific goals clients may discount real improvements that they or their children have made. Minimal and achievable goals are also most likely to enhance commitment to goals, especially with those clients who demonstrate a high locus of external control and who have a low sense of personal efficacy.

5. Specifying Problems for Work

Usually the problems for work are derived from those problems the client identified, those the worker identified or some negotiated compromise or combination of the two. They are the basic guide posts for all worker and client activities. The problems for work should be stated in clear and understandable terms. Usually the worker has used skills of reflecting the problem and sharing her view of the problem before she specifies problems for work. This requires the use of primary and advanced accurate empathy.

6. Primary level accurate empathy

Primary level accurate empathy means communicating initial basic understanding of what the client is feeling and of the experiences and behaviors underlying these feelings. It helps the client explore and clarify their problem situation from their frames of reference. In this response, helpers try merely to let their clients that they understand what they have explicitly said about themselves.
In most cases empathy helps to establish rapport with clients; it helps to them to explore themselves and their problem situation . It is both a relationship building and a data gathering or problem clarification skill

7. Advanced Accurate Empathy

Gets at not only what the client clearly states but also what they imply or leave only half stated or half expressed [Read examples]. If advanced empathy and other forms of challenging are used too early in therapy the client may be frightened off or inhibited in other ways. T here is no such thing as a good empathic response in itself. They are only good to the degree that they are instrumental in achieving the goals of the helping process. Accurate can deal with affect and /or content of a clients statement. The principal question: What is the core message in what the client is saying

8.Hints for Improving Empathy (Egan,1982,pp. 92-97))

- Give yourself time to think: During pauses ask yourself: What feelings has the client just expressed? What is the core message
- Short responses: helper's response should be relatively frequent but also neat and trim. Avoid being long winded especially when you see that you have not hit the mark.
- After you have responded, attend carefully to cues that either confirm or deny the accuracy of your response

- Be gentle , but don't let the client run from important issues

- Empathy of tone and manner: being fully with the client means participating in some reasonable and genuine way in their feelings.

- Language: communicate at the level of the client without using slang that is simply not your own

- Respond to both feeling and content unless there is a reason for emphasizing one or the other

- Note signs of client stress or resistance and try to judge whether these arise because you have lacked accuracy or have been perhaps too accurate

Common Problems

- Poor Substitutes for Empathy
  - -no response
  - -a question
  - -a cliché
  - -an interpretation
  - -moving to action

- Counterfeits of Accurate Empathy
  - -Inaccurate empathy: learn to pick up cues from their clients that they have been inaccurate and then work to get back with the client.
  - -Feigning understanding: if helpers feel that they don quite understand what clients are trying to say, they should be tentative in their responses and give the client room to move.
  - -Parroting

9. Exercise: The distinction between primary level and advanced empathy

10.Goal Setting: Making goals more and more concrete (Egan,1982,pp. 210-213)

A goal is what a client wants to do or accomplish in order to manage a problem situation or some part of it more effectively. Goals deal with what is to be accomplished. There are four levels of concreteness

Level I: Declaration of intent
Level II: General Mission statement
Level III: More specific aim
Level IV: More concrete goal

11. Checking goals against criteria (Egan,1982,pp. 212-218)

A -It must be an accomplishment, an achievement rather than a program
B- It must be behaviorally clear and specific
M-It must be measurable or verifiable
R-It must be realistic, that is , within the control of the client, within their resources, and environmentally possible
S-It must be adequate, that is, if accomplished, it should in substantive way contribute to the handling of the problem situation or some part of it.
V-It must be in keeping with the values of the client
T-It must be accomplished within a reasonable time frame

12. Exercise: Review hypothetical list of goals according to criteria

13. Exercise: Looking at the problem statement rate the accompanying goals according to the criteria. If necessary propose a reworded goal that does meet the above criteria.

14. Action Plan Ideas

Appendix E (continued)

In-service Staff Training: Session IV

1. Agenda: Specifying treatment goals: a model for the goal setting process with families

Learning Objective : Workers will develop a procedure to construct with clients a list of problems for work that reflect the client's priorities and which are also within the scope of the agency's mandate.

2. Helping the family decide what the treatment goals will be.

Clarification of treatment goals serves several purposes:

- Established goals can be consulted periodically to assess treatment progress.
- Treatment goals provide a basis for evaluating treatment outcome.
- Redefining problems as discrete behaviors to be changed makes overwhelming concerns seem more manageable.
- Goal setting begins to bring the family together to work on problems everyone has identified.
- Knowing in advance what behaviors the family wants to change or encourage makes the task of treatment more manageable for the worker.

Exercise : Helping others set concrete and specific goals

In this exercise you are asked to act as a helper/consultant to one of the members of your training group.

Procedure

a) Get a partner from among the members of your training group.
b) Decide which is to be the helper and which is to be the client.
c) If you are the client, give your partner a summary of some problem situation that you are trying to manage more effectively. Be as concrete and as specific as possible in this summary.
d) If you are the helper, after listening to the summary, use a combination of empathy, probes, and challenges to help your partner move from a declaration of intent to a concrete and specific with the characteristics outlined earlier. Do not set the goal for your partner. Rather, use your skills to get your partner to use his or her resources in setting some concrete and specific goals.
e) When you feel you have met your objective, stop the process and get feedback. If you are the client give feedback that is short and to the point.
f) Choose new partners with clients and helpers alternating.

3. Goal setting process: developing a therapist agenda

4. Completing Action Plan Forms

Appendix F

ACTION PLAN (Adapted from Austin, Brannon, and Pecora, 1984, p171)

Name:

Date:

Action Items

From the information presented in these workshops, I plan to: